Submit this document to:
Crime Victims Compensation Program
Department of Labor & Industries
Post Office Box 44520
Olympia, Washington 98504-4520

CVCP INITIAL RESPONSE AND ASSESSMENT: FORM II

Please submit this form if you are seeking authorization to provide more than six sessions**.** Payment will not be provided for additional sessions until Form II has been received. CVCP application for benefits must also have been processed and approved.

Bill Procedure Code 0123C For This Report.

Victim's Name		Cvcp Claim Number
Client's Name (if different than the victim's)		Date treatment began
Clinician's Name	Clinician's Provider Number (if known)	Number of sessions to date
Clinician's Address		Clinician's Phone Number ( )
City		State Zip+4

Please review the CVCP guideline on Initial Response, Assessment and Documentation Procedures and provide answers to the questions listed below. You may copy and complete this form, or send a narrative report that contains all of the points listed below.

1) What is the client's or caregiver's initial description of the crime incident for which they have filed a CVCP claim? If the victimization was not recent, please describe what brought the victim into treatment at this time.

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2) Briefly summarize the essential features of the victim's symptoms, related to the crime impact, beliefs/attributions, vulnerabilities, defenses and/or resources that led to your clinical impression (refer to the DSMIV and CVCP Initial Response Guideline):

3) Please describe pre-existing or co-existing emotional/behavioral or health conditions relevant to the crime impact if present, and explain how they were exacerbated by the crime victimization (e.g. depression, anxiety, vulnerabilities in personality structure, etc.).

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4) List diagnoses on all 5 Axes ***(be certain all diagnostic criteria are met).***

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V/Current GAF:

Highest GAF past year:

5) Treatment Plan (based on diagnosis and related symptoms, see the CVCP Initial Response Guideline)

A. What are the specific treatment goals that you and the victim have set? Please also list who, in addition to the victim, you expect to include in treatment sessions e.g., parent(s), significant other.

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B. What are the treatment strategies to achieve these goals?

C. How will you measure progress toward these goals?

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D. Describe auxiliary care that will be incorporated (e.g. psychiatric evaluation, medication management, spiritual healers, community services, other services).

6) Please describe your assessment of the victim's treatment prognosis, as well as any extenuating circumstances and/or barriers that might affect treatment progress (e.g., previious trauma history, preexisting emotional/behavioral or medical conditions, family and social

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7) Has the victim experienced time loss from work as a result of this victimization?

☐ No

☐ Yes; Please list the date(s) the person was unable to work and if applicable, give an estimated date of when the individual will return to work. Please explain why the time loss has occurred, the extent of impairment and the prognosis for future occupational functioning.

Dates:

Explanation: